

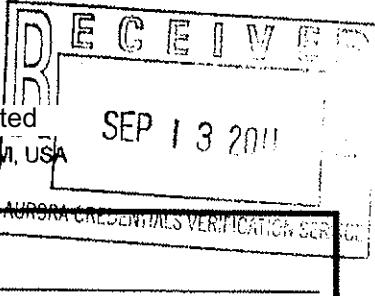
# Reappointment Application for Albert L Fisher MD

Home address: Redacted  
Oshkosh, WI 54902  
Home phones: Redacted  
Cell / Car phone: Redacted  
Pager: Redacted

General E-Mail: Redacted  
Confirm and/or correct:

Date of birth: 1952  
Sex: M  
Marital status: M  
Spouse: Redacted  
Birth place: Eau Claire, WI, USA  
Languages:

Credentialing E-Mail: Redacted  
Confirm and/or correct:



## Aurora Affiliations

Aurora Medical Center - Oshkosh

## Offices

## List All Current

Primary office: Yes Mailing address: Yes Billing address: No Secondary office: No

Office name: Redacted  
Address:

Answering service: Redacted  
Fax number: Redacted  
Tax ID:

City / St / Zip: Oshkosh, WI 54901-5227  
Phone 1: Redacted  
Phone 2: Redacted

Office contact: Redacted

Primary office: Mailing address: Billing address: Secondary office:

Office name:  
Address:

Answering service:  
Fax number:  
Tax ID:

City / St / Zip:  
Phone 1:  
Phone 2:

Office contact:

Primary office: Mailing address: Billing address: Secondary office:

Office name:  
Address:

Answering service:  
Fax number:  
Tax ID:

City / St / Zip:  
Phone 1:  
Phone 2:

Office contact:

## Work History

List any changes to your work history that have occurred within the past 2 years.

Primary office: Mailing address: Billing address: Secondary office:

Office name:  
Address:

Answering service:  
Fax number:  
Tax ID:

City / St / Zip:  
Phone 1:  
Phone 2:

Office contact:

Primary office: Mailing address: Billing address: Secondary office:

Office name:  
Address:

Answering service:  
Fax number:  
Tax ID:

City / St / Zip:  
Phone 1:  
Phone 2:

Office contact:

# Reappointment Application for Albert L. Fisher MD

## Board Certification

Specialty name: Family Medicine  
Primary specialty: Yes  
Eligible: No

Board name: American Board of Family Medicine  
Certified: Yes  
Certified year: Redacted  
Expiration date: Redacted

Specialty name:  
Primary specialty:  
Eligible:

Board name:  
Certified:  
Certified year:  
Expiration date:

## All Hospital and Surgery Center Affiliations Within the Past 3 Years

Facility: Aurora Medical Center - Oshkosh  
Address: 855 N Westhaven Dr  
Oshkosh, WI 54904

Status: Active  
From: 02/27/2004  
To: Present

Facility: Calumet Medical Center  
Address: 614 Memorial Dr  
Chilton, WI 53014-1568

Status: Active  
From: 03/07/2005  
To: Present

Facility: Mercy Medical Center  
Address: 500 S Oakwood Rd / PO Box 3370  
Oshkosh, WI 54903-3370

Status: Active  
From: 11/26/1985  
To: Present

Facility: Northstar Health System  
Address: 1400 W Ice Lake Rd  
Iron River, MI 49935

Status: Courtesy  
From: 02/01/2009  
To: Present

Facility: St Elizabeth Hospital/Affinity  
Address: PO Box 8010  
Menasha, WI 54952-8010

Status: Active  
From: 03/07/2005  
To: Present

Facility: St Elizabeth's Surgery Ctr  
Address: 1550 Midway Pl  
Menasha, WI 54952

Status: Active  
From: 03/07/2005  
To: Present

Facility: OSF St. Francis Hospital  
Address: 3401 Ludington St  
Escanaba, Michigan 49829

Status: E.O.  
From: 12/2009  
To: Current

Facility:  
Address:

Status:  
From:  
To:

## Education

Medical education: Medical College of Wisconsin  
From: 09/01/1976  
To: 05/31/1980

Graduation year: 1980  
Degree earned: MD  
Specialty:

Internship: St Luke's Medical Center  
From: 07/01/1980  
To: 06/30/1981

Graduation year:  
Degree earned:  
Specialty:

Residency: UIC-Rockford Family Practice Residency  
From: 07/01/1981  
To: 06/30/1982

Graduation year:  
Degree earned:  
Specialty: Family Practice

# Reappointment Application for Albert L Fisher MD

Residency: Southwestern Michigan Health Education Center  
From: 07/01/1983  
To: 06/30/1985

Graduation year:  
Degree earned:  
Specialty: Family Practice

Other:  
From:  
To:

Graduation year:  
Degree earned:  
Specialty:

## Licenses

License type:	ID number:	State:	Expiration date:
State License	Redacted	IL	Redacted
State License	Redacted	MI	Redacted
State License	Redacted	WI	Redacted
DEA Number	Redacted	WI	Redacted
Medicaid Provider	Redacted		
Medicare Provider	Redacted		
Medicare UPIN	Redacted		
ECFMG Number			
Certification			
WI Criminal Background Form		WI	Redacted
NPI Number	Redacted		Required

For general information and instructions on how to apply for this number, please visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

## Health Data

Health Item:	Expiration date:
TB Test	11/10/2007
+ TB Symptom Form	
Chest x-ray	
Rubella	
Physical Exam	

## Insurance

Insurance company:

Redacted

Policy number: Redacted  
Issued: Redacted

Expires: Redacted  
Amount per incident: Redacted  
Aggregate amount: Redacted

Certificate holder: Yes

**Reappointment Application for Albert L Fisher MD**

Insurance company:

**Redacted**

Policy number:

**Redacted**

Issued:

Expires:

Amount per Incident:

Aggregate amount:

**Redacted**

**Redacted**

Certificate holder:

Albert Fisher

## DISCLOSURE QUESTIONS

If you answer "YES" to questions number 2 through 18, please provide details on a separate page. Include a copy of any order or settlement where applicable.

1.	During the past 3 years, have there been, or are there currently, any professional or work-related claims, settlements or judgments against you, you and your employer, and/or other third party even if not resulting in monetary damages, or have you received any notice of "Intent to File" or a "Request for Mediation"? IF YOU ANSWER "YES," PLEASE PROVIDE DETAILED INFORMATION ON THE ENCLOSED PROFESSIONAL LIABILITY ACTION EXPLANATION FORM.		
2.	During the past 3 years, has there been any professional liability insurance coverage voluntarily or involuntarily canceled, declined or modified (i.e. reduced limits, restricted coverage) or has any renewal ever been refused, or have you voluntarily given up coverage?		
3.	During the past 3 years, have you voluntarily or involuntarily been denied membership, renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PPO, managed care organization or professional society, or is any such action pending?		
4.	During the past 3 years, have your clinical privileges or employment at any hospital or healthcare institution been voluntarily or involuntarily limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff or committee or governing board?		
5.	During the past 3 years, has your request for any specific clinical privileges been voluntarily or involuntarily denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff or committee or governing board?		
6.	During the past 3 years, have you had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?		
7.	During the past 3 years, have you been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?		
8.	During the past 3 years, have you been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services?		
9.	During the past 3 years, have you received notice of a proposed or actual exclusion from any health care program funded in whole or part by the federal government or any state health care program, including Medicare or Medicaid?		
10.	During the past 3 years, has your Drug Enforcement Agency or other controlled substances authorization ever been voluntarily or involuntarily denied, revoked, suspended, reduced or not renewed, or have proceedings toward any of those ends been instituted?		
11.	During the past 3 years, has your specialty board certification or eligibility ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended, reduced or have any proceedings toward any of those ends been instituted?		
12.	During the past 3 years, has your authorization to practice in any jurisdiction (state or county) ever been voluntarily or involuntarily revoked, suspended, or subject to probation or any conditions or limitations?		
13.	During the past 3 years, have you been convicted of, or pleaded guilty or no contenders to, a felony, serious or gross misdemeanor, or any crime involving dishonesty, assault or sexual misconduct or abuse, or are charges pending against you for any such crimes by information, indictment or otherwise?		
14.	During the past 3 years, to your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)?		
15.	Will practicing to the fullest extent of your licensure, qualifications and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients?		
16.	During the last ten years, have you been under the influence of alcohol during working hours or have you used illegal drugs?		
17.	During the past 3 years, have you been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?		
18.	During the past 3 years, if you perform clinical research, have you ever had any clinical research study terminated involuntarily, been asked to terminate a clinical research study before it was completed or had any other discipline or sanctions with respect to your clinical research?		
19.	Is your professional liability insurance current? (Please read this question carefully.)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Currently in residency or fellowship
20.	Do your professional liability insurance coverage amounts meet state minimum requirements? (Please read this question carefully.)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Currently in residency or fellowship

I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility. I understand and agree that the application will not be processed until the application is deemed complete by the healthcare organization. It is my responsibility to provide a "complete" application. I certify that the information in this document and any attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after staff membership/privileges or network participation has been awarded to me, may lead to suspension or termination of that

Albert L Fisher, MD

Name

Practitioner Signature (Stamped Signatures are Unacceptable)

*Albert L Fisher, MD*

Redacted

8/26/11  
Date

Albert Fisher, M.D.

Disclosure Questions.

**Redacted**

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**Redacted**

**Redacted**

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### BACKGROUND INFORMATION DISCLOSURE

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary, however your social security number is one of the unique identifiers used to prevent incorrect matches.

Please print your answers.

Check the box that applies to you.

- |   |  |
|---|--|
| <input type="checkbox"/> Employee / Contractor (Including new applicant)  | <input type="checkbox"/> Household member/lives on premises - but not a client |
| <input type="checkbox"/> Applicant for a license or certification or registration (including continuation or renewal) | <input checked="" type="checkbox"/> Other - specify: physician                 |

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) regulated facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix instructions.

Name - First and Middle Albert L	Name - Last Fisher	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)
-------------------------------------	-----------------------	--

Any other names by which you have been known (including maiden name)	Birthdate [Redacted] 1952	Gender (M/F) M	Race
--	------------------------------	-------------------	------

Address

Redacted

Business Name and Address of Employer or Care Provider (Entity)

Redacted

#### Section A - ACTS, CRIMES AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

YES NO

Redacted

- |    |  |
|----|--|
| 1. | Do you have criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts?<br>If Yes, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.  |
| 2. | Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.)<br>If Yes, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents. |
| 3. | Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked:<br>(Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.)<br>If Yes, explain, including when and where it happened.  |
| 4. | Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?<br>If Yes, explain, including when and where it happened.  |
| 5. | Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?<br>If Yes, explain, including when and where it happened.  |

(Continued on next page)

6.	Has any government or regulatory agency (other than the police) ever found that you abused an elderly person? If Yes, explain, including when and where it happened.	Redacted
7.	Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? If Yes, explain, including credential name, limitations or restrictions, and time period.	

Section B – OTHER REQUIRED INFORMATION		YES	NO
1.	Has any government or regulatory agency ever limited, denied or revoked your license, certification or registration to provide care, treatment or educational services?  If Yes, explain, including when and where it happened.	Redacted	
2.	Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?  If Yes, explain, including when and where it happened and the reason.		
3.	Have you been discharged from a branch of the US Armed Forces, including any reserve component?  If yes, indicate the year of discharge: _____ Attach a copy of your DD214 if you were discharged within the last 3 years.		
4.	Have you resided outside of Wisconsin in the last 3 years? If Yes, list each State, County within the State and the dates in which you lived there.		
5.	Have you had a caregiver background check done within the last 4 years? If Yes, list the date of each check, and the name, address and phone number of the person, facility or government agency that conducted each check.	Redacted	
6.	Have you ever requested a rehabilitation review with the Wisconsin Department of Health and Family Services, a county department, a private child placing agency, school board, or DHS designated tribe? If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.		

**A "NO" answer to all questions does not guarantee employment, residency, a contract or regulatory approval.**

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

<b>YOUR SIGNATURE</b>	<b>Date Signed</b>
<i>Albert Fisher</i>	8/23/11



# Aurora Health Care\*

## Practitioner Continuing Education Attestation Form

Name: **Albert L Fisher, MD**

I attest that I have completed the minimum number of acceptable continuing education hours (specific to my licensure as defined in the Wisconsin Administrative Code) in the previous two years since my appointment/last reappointment to the Medical Staffs of Aurora Hospitals and Surgical Centers and/or Select Specialty Hospital-Milwaukee.

To corroborate attested continuing education hours, a percentage of appointment and reappointment applications will be randomly reviewed. Those practitioners whose forms are reviewed will be required to present copies of continuing education certificates and hours earned.

Signature: Albert Fisher Date: 8/23/11

This form is required for consideration of your application for appointment or reappointment. Please return this completed form to the Aurora Credentials Verification Service Office with your application.

## **Consent and Release from Liability Form**

### **Authorization to Obtain Information.**

I understand that Aurora Health Care, Inc. is part of a health care system containing numerous affiliated hospitals, clinics and other facilities and organizations, a list of which is available at [www.aurorahealthcare.org](http://www.aurorahealthcare.org). I authorize and direct Aurora Health Care, Inc. and its authorized representatives (Aurora Health Care, Inc. and its authorized representatives collectively referred to as "AHC") and any affiliate of AHC at which I hold, have held or seek privileges or employment and its authorized representatives and medical staff members (an affiliate of AHC and its authorized representatives and medical staff members collectively referred to as "AHC Affiliate") to consult with and request information, including all information acquired in connection with the review and evaluation of health care services, from (1) representatives and members of hospital medical staffs with which I have been associated, including but not limited to AHC Affiliates, (2) representatives of educational facilities, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, and (3) any other organizations or individuals who may have information bearing on my background, qualifications, competence, training, experience, character, mental and physical health status, ethical qualifications, past and present malpractice coverage and claims, and any other matter having bearing on my requested medical staff appointment, reappointment, credentials and/or network participation (all such information collectively referred to as "Qualification Information"). I specifically authorize and direct these organizations and individuals to release to AHC and any AHC Affiliate(s), and to consult with AHC and any AHC Affiliate(s) regarding, any and all information, including all information acquired in connection with the review and evaluation of health care services, which they maintain or possess regarding my Qualification Information.

### **Authorization to Release Information.**

For the purpose of evaluating the health care services provided by me, I specifically authorize and direct the release of any information about me, maintained or possessed as a result of this consent and release, or through any other means, including but not limited to all information acquired in connection with the review and evaluation of health care services, (1) by AHC to any AHC Affiliate(s), and (2) by any AHC Affiliate to AHC and/or any other AHC Affiliate(s).

### **Release From Liability.**

I release from any and all liability AHC and all AHC Affiliates for their acts performed in good faith and without malice in connection with my application and its review, including but not limited to seeking and receiving the above referenced information. I release from any and all liability all individuals and organizations who may provide the above referenced information in good faith and without malice to AHC and/or any AHC Affiliate(s).

### **Burden of Providing Information.**

I agree and acknowledge that it is my obligation to provide to any AHC Affiliate at which I seek to obtain or maintain privileges or employment adequate information to process my application, and that my application will not be processed until it is deemed complete by the applicable AHC Affiliate. I further agree and acknowledge that it is my obligation to report in writing to the administrators of all AHC Affiliates at which I hold privileges or am employed if, during the term of my appointment or employment, there is any change in any of the information I have provided in this application, including but not limited to information regarding licensure, DEA status, insurance, malpractice claims, NPDB/HIPBB reports, medical staff discipline or criminal convictions. My failure to do so may be the basis for termination of privileges and/or employment.

### **Compliance with Medical Staff Bylaws.**

For each AHC Affiliate at which I hold or seek privileges or employment, I have had an opportunity to review a copy of the Medical Staff bylaws and policies as are in force at the time of my application. I agree to be bound by and comply with such Medical Staff bylaws and policies as they may be amended, in all matters related to the medical staff appointment and membership, without regard to whether or not appointment to the medical staff and/or clinical privileges are granted.

### **Placement of information on the AHC Website.**

I authorize AHC to post information about my affiliation with the hospital on its credentialing web site. I agree to review the information about me posted on the AHC website, and to notify AHC in writing of any inaccuracy. I understand that the public will have access to this information.

**Use of Photocopy or Facsimile.**

I agree that a photocopy or facsimile of this document with my signature may be accepted by any organization or individual from which the above referenced information is requested, with the same authority as the original. I specifically waive any notice obligation on the part of such organizations or individuals to inform me when they provide information to AHC, any AHC Affiliate(s), or any other third party based on this consent and release.

**Research Activities.**

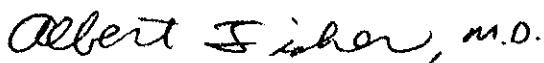
I acknowledge and agree that if I engage in any research whatsoever (including but not limited to data collection or review of medical records or databases for research purposes) on human subjects at any AHC Affiliate, I shall conduct such research in accordance with Aurora Institutional Review Board ("IRB") policies and applicable federal regulations. Specifically, I agree to give prior written notice of any such research to the Aurora IRB.

**Unenforceable Oral Agreements and Arrangements.**

AHC and the AHC Affiliates are committed to establishing policies and developing effective internal controls that will promote adherence to applicable legal requirements and ensure compliance with the principles and guidelines established under AHC's and AHC Affiliates' Compliance Program. These ongoing efforts require compliance with all laws, not only with respect to the delivery of health care, but also with respect to its business affairs and dealings with physicians. Accordingly, in the event a written agreement is necessary to qualify for an exception and/or avoid liability under applicable law, including without limitation, the physician self referral prohibition statute, commonly referred to as the "Stark Law," no oral agreement or arrangement between AHC and the AHC Affiliates and any physician (or a member of a physician's immediate family), pursuant to which any remuneration is to be provided to such physician (or a member of a physician's immediate family), shall be enforceable, and all such oral agreements and arrangements shall be considered null and void with no force and effect. Accordingly, except in rare circumstances defined as exceptions under the Stark Law as agreed to by the Medical Center and the applicable physician, all agreements and arrangements between AHC and the AHC Affiliates and any physician (or a member of a physician's immediate family), pursuant to which any remuneration is to be provided to such physician (or a member of a physician's immediate family), must be in writing, signed by both parties, and meet the requirements of all applicable laws. For purposes of this paragraph, the terms "physician" and "member of a physician's immediate family" shall have the meanings prescribed to such terms in 42 CFR § 411.351.

**Limitations.**

The foregoing shall remain in effect as a full authorization unless and until revoked in writing by the undersigned.



8/26/11

Please sign within the box above (Stamped Signatures are Unacceptable)

Date

Albert L Fisher, MD

Name

AURORA HEALTH CARE  
12500 West Bluemound Road #304  
Elm Grove, WI 53122-2602

# Wisconsin Department of Safety and Professional Services

## Web Applications

[Login](#)[Application](#)[Status](#)[DSPS Home](#)[Page](#)[License Lookup](#)[Main Menu](#)[PIN Lookup](#)

### Wisconsin Credential Lookup

#### Credential Summary - Details

Redacted

Name:
Credential Type:
Credential Number:
Location:
License Type:
Status
Eligible To Practice:
First Fee Received:

[Details](#)[Requirements](#)[Payments](#)[Orders](#)[Details](#)

License current through:
Granted date:
Multi-state:
Orders:
Specialties:
Other Names:

Redacted

Consistent with JCAHO and NCQA standards for primary source verification.

Data on this page is refreshed hourly.

[Send Questions or Comments to dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)

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# Redacted

For technical support, questions about using your account, and help using the website, please consult the [FAQ section](#), e-mail [dea@gim.net](mailto:dea@gim.net), or call 800.538.3539. [Click here](#) to read the terms and conditions of use for the website.

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DEPARTMENT OF JUSTICE CRIME INFORMATION BUREAU

# Redacted

The response is based on a search using the identification data supplied.

Searches based solely on name and non-unique identifiers are not fully reliable. The CIB cannot guarantee that the information furnished pertains to the individual you are interested in.

No criminal history found.

11/9/11  
mbs

Scott Walker  
Governor

Dennis G. Smith  
Secretary DHS



State of Wisconsin

Department of Health Services

DIVISION OF ENTERPRISE SERVICES

1 WEST WILSON STREET  
P.O. BOX 7850  
MADISON WI 53707-7850

dhs.wisconsin.gov

Date: November 9, 2011

From: The Department of Health Services,  
The Department of Children and Families and  
The Department of Regulation and Licensing

Re:

**Redacted**

On November 9, 2011, we received notice from the Department of Justice (DOJ) that you requested a Caregiver Background Check for the above named individual. You are receiving this letter per the requirements of sections 48.685 and 50.065 of the Wisconsin Statutes.

The Department of Health Services (DHS) and the Department of Children and Families (DCF) provides the following information in this letter:

- a) Noncredentialed Caregiver Findings of Abuse or Neglect of a Client; or Misappropriation of a Client's Property - A name listed in this area may prohibit employment or licensure for that person.
- b) Denials or Revocations of Operating Licenses for Adult (Chapter 50) Programs - A name listed in this area may prohibit employment or licensure for that person.
- c) Denials or Revocations of Operating Licenses for Child (Chapter 48) Programs - A name listed in this area may prohibit employment or licensure for that person.
- d) Rehabilitation Review Findings - A name listed in this area means that the individual has completed a rehabilitation review and the outcome may affect employment or licensure.

The Department of Regulation and Licensing (DRL) search results also appear in this letter and are listed as:

- e) Status of Professional Credential(s), License(s), or Certificate(s) - This section lists each professional credential, license, and certificate held by the individual. If an individual's name appears, note the "Eligible to Practice" indicator. If you have questions, contact the listed phone number.

The Department of Justice, Wisconsin criminal records search results are returned in a separate letter and are not part of this letter.

Before contacting one of the state agencies regarding the accuracy of the results of the electronic search, please verify that the name, date of birth, and Social Security Number shown at the beginning of this letter in the "Re" section match the name, date of birth, and Social Security Number of the original request.

NOTE: If you need TTY support, call (608) 266-7376 instead of the numbers listed in the rest of this letter.

Enclosure: Response to Caregiver Background Check.

**Electronic Search Results from the Department of Health Services (DHS) and the Department of Children and Families (DCF)**

**a. Noncredentialed Caregiver Findings of Abuse or Neglect of a Client; or Misappropriation of a Client's Property in Wisconsin**

Redacted

**Redacted**

If additional information is needed, contact the DHS Division of Quality Assurance at (608)261-8319.

**Noncredentialed Caregiver Findings of Abuse or Neglect of a Client; or Misappropriation of a Client's Property Out of State**

Redacted

**Redacted**

If additional information is needed, contact the DHS Division of Quality Assurance at (608)261-8319.

**b. Denials or Revocations of operating Licenses for Adult (Chapter 50) Programs**

Redacted

**Redacted**

**c. Denials or Revocations of operating Licenses for Child (Chapter 48) Programs**

Redacted

**Redacted**

If additional information is needed, contact the Department of Children & Families at (608)266-8001.

**c. Denials or revocations of Operating Licenses for BPOHC**

Redacted

**Redacted**

If additional information is needed, contact the Bureau of Permanency and Out of Home Care at (608)264-6944.

**d. Rehabilitation Review Findings Time Matters**

Redacted

Redacted

Redacted

If additional information is needed, contact the DHS Office of Legal Counsel at (608)266-8428.

**Electronic Search Results from the Department of Regulation and Licensing (DRL)**

NOTE: All information provided is public record. Please ignore names that do not match the name you requested.

**e. Status of Professional Credential(s), License(s) or Certificate(s)**

Name: Albert L Fisher

Previous Name(s): ALBERT L FISHER

ALBERT L FISHER JR MD

ALBERT L. FISHER

Redacted

Address:

Credential Description: Medicine and Surgery

Credential #: Redacted

Granted On: Redacted

Valid Until: Redacted

Credential Type: Redacted

Eligible to Practice: Yes

If you believe this is incorrect or incomplete, see [www.drl.state.wi.us](http://www.drl.state.wi.us) and click on License Lookup. Print the results and file with this letter.

For additional information related to licensing of Health Professionals, please contact the Department of Regulation and Licensing at (608) 266-8794.

For additional information related to licensing of Business Professionals or Nursing Home Administrators contact (608) 261-2390 .

To verify the employment eligibility of a nurse aide, search the Wisconsin Nurse Aide Registry at [www.pearsonvue.com](http://www.pearsonvue.com).

**NOTE: The Department of Health Services, the Department of Children and Families and the Department of Regulation and Licensing cannot guarantee that the information furnished pertains to the individual in whom you are interested.**